



LIMITED ENGLISH PROFICIENT/ SENSORY IMPAIRED (LEP/SI)
DISCRIMINATION COMPLAINT FORM

If you have question about this form, call DHS's LEP/SI Program Office at:
404-657-5244

YOUR FIRST NAME		YOUR LAST NAME	
HOME PHONE ()		ALTERNATE PHONE ()	
STREET ADDRESS		CITY	
STATE	ZIP	E-MAIL ADDRESS (If available)	

Are you filing this complaint for someone else? ☐ YES ☐ NO

If Yes, include name below

FIRST NAME LAST NAME

I believe that I have been (or someone else has been) discriminated against on the basis of :

☐ Race/ Color / National Origin ☐ Hearing Impairment ☐ Visual Impairment

Who do you think discriminated against you (or someone else)? Be specific

PERSON/ AGENCY / ORGANIZATION

STREET ADDRESS		CITY
STATE	ZIP	PHONE ()

When and where do you believe that the discrimination took place? Be Specific

LIST DATE(S) AND LOCATION(S)

Describe briefly what happened. How and why do you believe you (or someone else) were discriminated against? Please be as specific as possible. (Attached additional pages as needed)

Please sign and date this complaint.

SIGNATURE

DATE



(The remaining information on this form is optional. Failure to answer the question below will not affect this complaint in any way.)

Do you need special accommodation for us to communicate with you about this complain (check all that apply)?

- ☐ Braille ☐ Large Print ☐ Cassette Tape ☐ Computer diskette ☐ Electronic mail ☐ TDD
- ☐ Sign Language Interpreter (specify language):
- ☐ Foreign Language interpreter (specify language): ☐ Other:

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME		LAST NAME	
HOME PHONE ()		ALTERNATE PHONE ()	
STREET ADDRESS		CITY	
STATE	ZIP	E-MAIL ADDRESS (if available)	

Please type or print, and return completed complaint form to:

**DHS LEP/SI Program
Two Peachtree Street, N.W.
Suite 29-103
Atlanta, Georgia 30303-3142
(404) 657-5244 Fax: (404) 651-5444**